

eASOAP FORM

ADMINISTRATIVE

The member is allowed for **Out Patient**

at the **CITICARE MEDICAL CENTER LLC**

Patent Name:	THAER MOHAMAD DHIMCH	Gender:	Male	Validity Between:	06/08/2024 and 30/04/2025
Card No:	61E4-892D-1E70-75BF	DOB:	7/20/1979 12:00:00 AM	Coverage Informaton for:	Out Patient
Pin #:		Identty Card:		Network:	RN UAE (Al Ansari-AUH)-MEDGULF
Natonal ID:	784-1979-2713721-2	Service Date:	07-Jan-2025	Radiology:	Covered
		Patent's Tel No:	0527059299		
Policy Holder:		Threshold Limit:			
Payer Name:	ORIENT INSURANCE P.J.S.C	Class:	Normal		
		Out-Patent :			
Category:	Category B	Patent's File No:	44589	Pharmacy:	Co-Part: 20%
Gatekeeper:	No	Consultaton :		Laboratory:	Covered
Referral No:					
Referred Service:					

SUBJECTIVE ASSESSMENT

Symptom(s) as described by the patent (Chief Complaint):						Date of Symptoms/illness started		
Complaint						DD	MM	YYYY
pc : loose stool for 1 day , vomitting for 1 day not assoxiated with fever								
no other med condition								
o/e look pale								
Past Medical Surgical History?						Date of Symptoms/illness started		
☐ Yes ☐ No						DD	MM	YYYY
Obs/Gyn Claims						Date of Symptoms/illness started		
☐ Para ☐ Gravida: ☐ AB: LMP: Marital Status: Marital Date:						DD	MM	YYYY
What date did the Patient first feel same / similar Symptom(s) : dd mm yyyy								
Is the Patient under any type of Treatment? ☐ Yes ☐ No if yes, indicate what Assessment and since when:								

OBJECTIVE / ASSESSMENT(To be completed by Physician)

Clinical Findings :		Vital Signs : B/P : 120 T : 36.4 HR : 94 RR : 18	
Assessment/Diagnosis : ☐ Acute ☐ Chronic ☐ Confirmed ☐ Suspected			
INDICATE DIAGNOSIS NOT SYMPTOM			
Type	Code	Diagnosis	
Primary	K29.00	Acute gastritis without bleeding	
Secondary	R19.7	Diarrhea, unspecified	
Secondary	E86.0	Dehydration	

ACCIDENT/OCCUPATIONAL Claim Informaton (complete if claim is a result of accident or work related illness/injury)

--

Accident or illness due to work?		Injury due to road accident?		Describe how the accident or work related injury/illness occur:	
☐ Yes ☐ No		☐ Yes ☐ No			
Date of accident or beginning of illness:					
MEDICAL PLAN Itemized Original Invoices and Applicable Prescriptions / Reports / Results must be enclosed to consider claim					
CPT Code	Treatment	Type	Price		
0102-152902-1001	LACTATED RINGERS INJECTION USP	Pharmacy	5.0000		
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Co.Pay	5.0000		
0005-150403-1021	PREMOSAN	Pharmacy	0.9000		
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Co.Pay	3.0000		
0195-107704-0801	CEFTRIAXONE-TABUK IV	Pharmacy	48.5000		
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Co.Pay	40.0000		
86141	C-reactive protein; high sensitivity (hsCRP)	Lab	30.0000		
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Lab	15.0000		
Code	Generic	Duration	Instructions		
0097-708002-0831	(TRISODIUM CITRATE DIHYDRATE : 0.58G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CHLORIDE : 0.52 G) (DEXTROSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION	3	Take 1Powder 1Time(s) perDay For 3 Day(s) others		
1795-502202-1451	(SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN)	30	Take 1 Unit(s), 1 Time(s) per Day For 30 Day(s)		
0248-187801-1171	(DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS	3	Take 1Tablets 2 Time(s) per Day For 3 Day(s) others		
0415-200001-1452	(LOPERAMIDE : 2 MG) CAPSULES (HARD GELATIN)	2	Take 2 caps now then 1 cap after every loose stool		
☐ Pharmacy:		Estimated Costs		☐ Laboratory / Radiology:	
				Estimated Costs	
Is the following required		☐ Surgery:		☐ Endoscopy:	
		☐ Physiotherapy:		☐ Other Procedures:	
				If yes please specify	
Is In-patient Required ? Length of Stay		Indicate Provider		Estimate Cost	
I hereby certify that all informaton mentoned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case.		I hereby authorize any Healthcare Provider, Insurer, Employer or other Organizaton to release any informaton regarding my medical conditon and history to NEXtCARE for the purpose of determining insurance benefsts. Medical management is the sole responsibility of doctor and the patent.			
Treating Physician Name : SANDIA					
Tel / Fax (important):					



Signature & Stamp



Patient's Signature(Parent if minor)



Date :

Date : 07-Jan-2025

Note: Claims must be submitted along with supporting documents within 30 days from date of service

Disclaimer: NEXtCARE ASOAP form is used for claim creation purposes. The data contained here should always be carefully reviewed. NEXtCARE will not be held responsible for misuse of claims submission's or any adverse effects caused due to the claims submissions. NEXtCare assumes no responsibility for any discrepancies or errors contained in this pre-printed datasheet and final opinion will be given by the NEXtCARE claims doctors.